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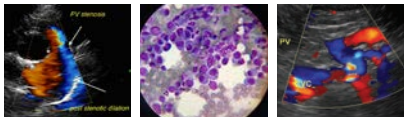

SonoPath
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DATE

6/7/22

PATIENT

Tabby Wise

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

9/22/15

WEIGHT

14.1 Pounds

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Rachel Brilhart RDMS

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. King

INVOICE

38450

PRESENTING CLINICAL SIGNS

Seen here in September possible trouble breathing-- but ultimately feel was probably related to hyperthyroidism, currently on 1.25 mg PO BID, T4 testing at low normal- where Dr. Petrus wants it DM-- started insulin in December 1 unit glargine , Fructosamine in 300's -- where he wants it last check in Feb? has not had full curve recently Has had US with Dr. Petrus-thickened wall of bowel (musclaris promiment), but was not overtly concerned at that time PC-- hyporexia to anorexia has not given insulin

Current Medications: Lantus, mirtazapine, methimazole, maropitant
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney is normal in size (4.0 cm) with irregular contour shape. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (3.86 cm) and irregular in shape. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.33 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a mild amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.36cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is normal to slightly increased. Bowel loops follow a typical curvilinear path with distinct wall layering, but some areas display a prominent muscularis layer which does not display the typical 1:3 muscularis:mucosa layer ratio. Jejunum wall measured 0.27 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The pancreas is prominent and mottled compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid. Prominent pancreatic duct noted at 0.28 cm.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Prominent muscularis layer to the small intestine – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.

- Mottled, prominent pancreas with prominent pancreatic duct – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.

- Decreased corticomedullary distinction in both kidneys with irregular contours – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The pancreas is prominent on today's scan, and the small intestine appears somewhat "ropey". These changes can be commonly seen in some older diabetics, but can also be associated with active disease.

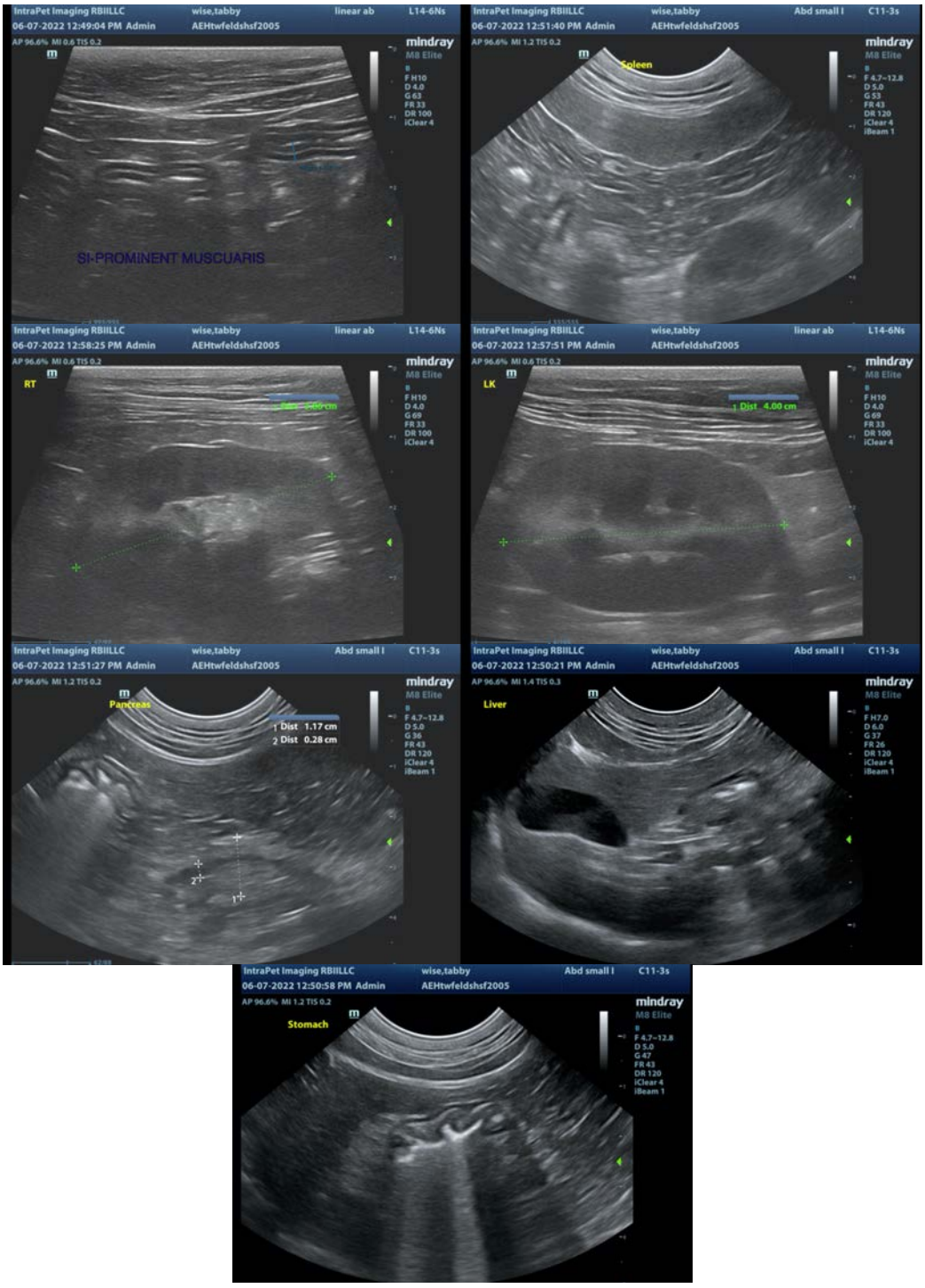
The changes observed in the pancreas could be consistent with current active inflammation or with previous resolving inflammation. Consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine.

The small intestine appears subjectively prominent with a prominent muscularis layer. This can be seen with underlying inflammation.

- Consider a novel protein/hydrolyzed protein prescription diet.
- Consider the aforementioned GI panel.
- Consider chronic probiotic therapy.

- If symptoms persist, consider obtaining GI biopsies, as this is not a patient I would consider starting empirical steroid therapy with.

My suspicion is that this is a patient with chronic pancreatitis/pancreatic disease.



The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)
kathleen.sennello@sonopath.com